

NARCOTIC ADDICTION AND CRIMINAL RESPONSIBILITY UNDER *DURHAM*

ADDISON M. BOWMAN*

This article relates the Durham rule of criminal responsibility to the narcotic addict. After reviewing the leading cases refining the Durham rule in the District of Columbia, the author examines the medical literature describing the disease of addiction. Finally, he analyzes this disease in terms of criminal responsibility under Durham, and concludes that a showing of addiction should be sufficient to present a jury question of insanity. His analysis also includes suggestions for the presentation of the insanity defense in this type of case.

Although the medical profession has long recognized narcotic addiction as an illness, the law has only recently begun to view the addict as a sick person. Until *Robinson v. California*,¹ decided by the Supreme Court in 1962, it was possible for a state to enact legislation authorizing punishment of the addict,² not because of his possession or use of narcotics, but solely because of his addiction. The attitude of the law toward the addict has been shaped partly by misconception and ignorance,³ and partly by persistent emphasis of the goals of suppression and eventual elimination of narcotic use through the imposition of severe penalties for violations of the narcotic laws.⁴ Until quite recently, the impact of narcotic addic-

* Staff Attorney, Legal Aid Agency, Washington, D.C. A.B., Dartmouth College; LL.B., Dickinson School of Law; LL.M., Georgetown University Law Center.

¹ 370 U.S. 660 (1962). This case invalidated a California statute which authorized criminal conviction for use of narcotics *or* for addiction to narcotics, on the ground that imprisonment based upon addiction alone constitutes cruel and unusual punishment violative of the eighth and fourteenth amendments.

² As of October 1961 at least sixteen states had statutes in force making addiction a crime punishable by imprisonment. See AMERICAN BAR FOUNDATION, NARCOTICS AND THE LAW 149-93 (1962).

³ There can be little doubt that nonmedical use of narcotic drugs is repugnant to the religious and philosophical heritage of the American people. *Id.* at 13-14. Nevertheless, as the *Robinson* Court pointed out, we would be loathe to punish those afflicted with leprosy or venereal disease. 370 U.S. at 666. There is nothing inherently evil about the abuse of narcotics; rather it is a medically recognized disease which requires treatment, not incarceration.

⁴ The myth of deterrence in the area of narcotics suppression has been dealt a severe blow by the President's Advisory Commission on Narcotic and Drug Abuse, headed by Circuit Judge E. Barrett Prettyman, which reported:

The Bureau of Narcotics maintains that the present severe penalties act as a powerful deterrent. The Commission does not agree. As the Commission pointed out in its introduction, it is difficult to believe that a narcotic addict who is physically and psycholog-

tion on criminal responsibility had been given little or no attention. Several recent decisions in the District of Columbia, where the *Durham*⁵ formulation of legal insanity prevails, however, recognize that the addict may not be criminally responsible for some of his antisocial behavior.⁶ In short, he may be legally insane. This article will attempt to explore the relationship of narcotic addiction to criminal responsibility, the ultimate question being: to what extent can the addict⁷ accused of crime avail himself of the insanity defense under the *Durham* rule?⁸

ically dependent on a drug will forego satisfaction of his craving for fear of a long prison sentence The weakness of the deterrence position is proved every day by the fact that the illicit traffic in narcotics and marijuana continues.

THE PRESIDENT'S ADVISORY COMM'N ON NARCOTIC AND DRUG ABUSE, FINAL REPORT 40 (1963) [hereinafter cited as PRESIDENT'S REPORT].

A similar position was recently taken by the Advisory Council of Judges of the National Council on Crime and Delinquency, which stated that the federal and state laws outlawing possession of narcotics actually aid underworld traffickers because physicians are deterred from treating the addicts, who are then forced to turn to illegal sources. "The narcotic addict is a sick person, physically and psychologically, and as such is entitled to qualified medical attention just as are other sick people." Washington Post, June 22, 1964, p. A3, col. 4-5.

⁵ *Durham v. United States*, 94 U.S. App. D.C. 228, 214 F.2d 862 (1954); see pp. 1021-22 *infra*.

⁶ See *Castle v. United States*, — F.2d — (D.C. Cir. 1964); *Horton v. United States*, 115 U.S. App. D.C. 184, 317 F.2d 595, 596 (1963). In two recent trials in the United States District Court for the District of Columbia, addicts were found not guilty by reason of insanity because of their addiction. *United States v. Brown*, Crim. No. 274-63, March 31, 1965; *United States v. Prince*, Crim. No. 349-63, March 17, 1964, discussed in Washington Post, March 18, 1964, p. B6, col. 1; cf. *Brown v. United States*, 331 F.2d 822 (D.C. Cir. 1964); *Hightower v. United States*, 117 U.S. App. D.C. 43, 325 F.2d 616 (1963). But see *Heard v. United States*, — F.2d — (D.C. Cir. 1964), *petition for rehearing en banc denied, opinions and order modified*, No. 18290, May 12, 1965, which held that a showing of narcotic addiction, without more, did not raise a jury issue of criminal responsibility so as to require an instruction on insanity.

⁷ For purposes of this article, an "addict" is one who has developed physical and psychological dependence on a narcotic drug of the opiate class or a synthetic equivalent. Narcotic drugs in the opiate class include opium, morphine, heroin, dionon, dilaudid, metopon, codeine, eucodal and dicodide. Their synthetic equivalents include demerol, methadone, dromoran, phenazocine and leritine. These drugs all vary in addiction liability. Excellent descriptions of these drugs are found in MAURER & VOGEL, *NARCOTICS AND NARCOTIC ADDICTION* 53-72 (2d ed. 1962).

Note that this listing excludes addicting nonopiate sedatives such as barbiturates, bromides and marijuana, and stimulant drugs, such as cocaine and benzedrine. There are several reasons for this exclusion: almost all of today's addicts use drugs of the opiate class; these nonopiate drugs affect the user in many different ways; and many of the generalizations regarding opiate addiction do not hold true for these other drugs. The effects of these drugs are described in MAURER & VOGEL, *op. cit. supra* at 90-128.

Statistics published by the Federal Bureau of Narcotics indicate that, of the 47,489 addicts reported as of December 31, 1962, all but ninety-seven were addicted to an opiate or syn-

Brown v. United States

The *District of Columbia Code* provides that whenever a person is arrested and, prior to the imposition of sentence

it shall appear to the court from the court's own observations, or from prima facie evidence submitted to the court, that the accused is of unsound mind or is mentally incompetent so as to be unable to understand the proceedings against him or properly to assist in his own defense, the court may order the accused committed [to a mental hospital for examination and observation].⁹

The purpose of such commitment, which is normally accomplished prior to trial, is twofold: to permit a determination of competency to stand trial, and to provide a reliable opinion on the matter of criminal responsibility for use at the trial itself.¹⁰ Indeed, this form of commitment is often the only means by which an indigent accused can secure expert opinion evidence for the insanity defense. While it is by no means clear what quantum of evidence will justify or require pretrial commitment under this provision, it is at least settled that less evidence than that amount neces-

thetic equivalent. *Hearings Before a Subcommittee of the House Committee on Appropriations*, 88th Cong., 1st Sess. 458 (extract from TREASURY-POST OFFICE DEPT'S & EXEC. OFFICE APPROPRIATIONS FOR 1964). In addition, the FBN reports that ninety-four per cent of these addicts are addicted to heroin, and that this preference for heroin has existed for the last ten years or more. *Id.* at 467. These figures do not include marijuana users because, since marijuana does not produce physical dependence in the user, the FBN does not consider it an addicting drug. Note, however, the World Health Organization's definition of drug addiction, which apparently contemplates some addiction without physical dependence. See note 94 *infra*.

⁸ No examination of the *M'Naghten* formulation of criminal responsibility, which excuses only those who do not understand either the nature or wrongfulness of their conduct, will be offered, for it would seem clear that the vast majority of addicts who commit criminal acts understand the nature and quality of their acts and appreciate the wrongfulness of their conduct. The *M'Naghten* rule has been roundly criticized by psychiatrists and jurists as unrealistic and outmoded in the light of modern psychiatry and psychology. See, e.g., Cardozo, *What Medicine Can Do for the Law*, in *LAW AND LITERATURE* 101, 109 (1931). However, even today this rule prevails in all states save New Hampshire, notwithstanding opportunities for change. See, e.g., *Commonwealth v. Melton*, 406 Pa. 343, 178 A.2d 728 (1962); *Commonwealth v. Woodhouse*, 401 Pa. 242, 164 A.2d 98 (1960).

⁹ D.C. CODE ANN. § 24-301(a) (1961). This section provides for commitment for a "reasonable period" to the District of Columbia General Hospital or other mental hospital. In practice, most commitments from the United States District Court for the District of Columbia, which tries all felony offenses in the District, go to Saint Elizabeth's Hospital for a period of about sixty days.

¹⁰ Although the statute addresses itself only to the problem of trial competency, it has been held that the hospital should report to the court on the question of criminal responsibility as well. *Winn v. United States*, 106 U.S. App. D.C. 133, 270 F.2d 326 (1959).

sary to raise a jury question of criminal responsibility will suffice.¹¹ The rationale is that, were the accused in possession of conclusive evidence of mental illness, he would have no need for further mental observation.¹²

Brown v. United States,¹³ decided April 10, 1964, held that, since "the defense of insanity based on drug addiction generally presents a jury issue as to criminal responsibility,"¹⁴ an accused addict who moves for mental examination is entitled to the assistance of the court in developing the basis for his insanity defense. Defendant Brown had moved for a mental examination, alleging a history of narcotic addiction which was uncontroverted by the Government. The denial of this motion¹⁵ and the denial of motions to subpoena psychiatrists were the sole issues presented on appeal. The court of appeals has thus unequivocally concluded that narcotic addiction constitutes prima facie evidence of mental illness for purposes of pretrial mental observation. This decision should be quite persuasive in other jurisdictions which utilize tests for criminal responsibility similar to *Durham* and which provide for pretrial mental observation at government expense.¹⁶

¹¹ *Mitchell v. United States*, 114 U.S. App. D.C. 353, 359, 316 F.2d 353, 360 (1963). Considering that only "more than a scintilla" of evidence is needed to raise the issue of criminal responsibility, see *McDonald v. United States*, 114 U.S. App. D.C. 120, 312 F.2d 847 (1962) (en banc), it would seem that very little evidence indeed would satisfy the statutory standard, "prima facie evidence," thus construed. However, the indigent, unable to hire a psychiatrist for this purpose, is often hard put to produce any evidence at all unless he has a history of mental illness.

¹² *Mitchell v. United States*, *supra* note 11, at 359, 316 F.2d at 360.

¹³ 331 F.2d 822 (D.C. Cir. 1964).

¹⁴ *Id.* at 823, citing *Horton v. United States*, 115 U.S. App. D.C. 184, 317 F.2d 595 (1963), and *Hightower v. United States*, 117 U.S. App. D.C. 43, 325 F.2d 616 (1963). *But see* *Heard v. United States*, — F.2d —, — n.3 (D.C. Cir. 1964), discussed pp. 1025-26 *infra*.

¹⁵ In all, the defendant had moved three times for a mental examination, and had moved twice to subpoena a psychiatrist. All these motions had been denied.

¹⁶ 18 U.S.C. § 4244 (1958), applicable in United States district courts, provides that upon a showing that an accused "may be presently insane or otherwise so mentally incompetent as to be unable to understand the proceedings against him or properly to assist in his own defense," the court shall cause the accused to be mentally examined by at least one qualified psychiatrist. Under this section the court may also order commitment to a mental hospital for observation.

Decisions construing this provision do not spell out clearly the requirements for a prima facie showing of insanity or incompetency, except that the motion must be nonfrivolous and presented in good faith. See *Kenner v. United States*, 286 F.2d 208 (8th Cir. 1960); *Wear v. United States*, 94 U.S. App. D.C. 325, 218 F.2d 24 (1954). However, in *Krupnick v. United States*, 264 F.2d 213 (8th Cir. 1959), a narcotic addict who had been convicted of uttering forged prescriptions was successful in obtaining a reversal in the court of appeals

THE LEGAL FRAMEWORK

In 1895, the Supreme Court, in *Davis v. United States*,¹⁷ set forth certain basic rules for the guidance of federal courts in criminal cases wherein the defense of insanity is raised. Every defendant, stated the Court, is to be presumed sane until "some evidence" is offered to rebut this presumption.¹⁸ Once the presumption is rebutted, the Government, in order to convict, must produce evidence which, together with the presumption of sanity, excludes beyond a reasonable doubt the hypothesis of insanity.¹⁹ This allocation of proof is irrespective of any test for criminal responsibility, although it is at once apparent that the weight of the Government's burden is directly related to the prevailing criteria for criminal responsibility. It follows that federal decisions concerning criminal responsibility since 1895 have been primarily concerned with defining the qualitative and quantitative standards the Government must meet to prove sanity beyond a reasonable doubt.

Growing dissatisfaction with the *M'Naghten* standards of criminal responsibility led to the 1954 *Durham v. United States*²⁰ decision by the United States Court of Appeals for the District of Columbia Circuit. The court rejected the *M'Naghten* rules, because they placed undue emphasis on the cognitive element, which, the court noted, is not the sole or even the most important symptom of mental disorder. Rather than rest the determination of criminal responsibility on any symptom of mental illness, the court decided to adopt a test which would allow

because he had been denied a mental examination, although apparently the only evidence presented to the trial court on this question was that the defendant had been a user of narcotics for a considerable period of time. A similar result was reached under similar facts, including narcotic addiction, in *Lloyd v. United States*, 101 U.S. App. D.C. 116, 247 F.2d 522 (1957).

¹⁷ 160 U.S. 469 (1895).

¹⁸ *Id.* at 486-87.

¹⁹ The Court articulated the test as follows: "If the whole evidence, including that supplied by the presumption of sanity, does not exclude beyond reasonable doubt the hypothesis of insanity, of which some proof is adduced, the accused is entitled to an acquittal of the specific offense charged." *Id.* at 488. This rule has been modified to the following extent: the fact that the defense produces "some evidence" of insanity does not necessarily require acquittal in the absence of government rebuttal testimony, because the quanta of evidence required to raise the issue and to compel a directed verdict (even when uncontradicted) are different. In *McDonald v. United States*, 114 U.S. App. D.C. 120, 312 F.2d 847 (1962), the court stated: "Whether uncontradicted evidence, including expert opinion evidence, which is sufficient to raise a jury question on the mental issue is also sufficient to require a directed verdict depends upon its weight and credibility." *Id.* at 123, 312 F.2d at 850.

²⁰ 94 U.S. App. D.C. 228, 214 F.2d 862 (1954).

the trier of fact to view the entire mental makeup of the accused in its relationship to the crime with which he stands charged. This was accomplished with the disarmingly simple phrase: "[A]n accused is not criminally responsible if his unlawful act was the product of mental disease or mental defect."²¹ In practical effect, this meant that henceforth the Government would be required, upon a showing of some evidence of mental disorder, to prove beyond a reasonable doubt either that the accused had no mental disease or defect, or that the criminal activity charged was not the product of mental disease or defect. By way of definition the court merely stated that a "disease" was a condition capable of improving or deteriorating, and that a "defect" was a condition not capable of improving or deteriorating which might be congenital, the result of injury or the residual effect of a physical or mental disease.²² Ten years of experience with the *Durham* rule have clarified and refined the terms "mental disease," "mental defect" and "product." No further discussion of the term "mental defect" will be undertaken here; however, many of the decisions purporting to delimit the concept of mental disease also concern themselves, in general terms, with mental defects.²³

The problems which have arisen in connection with the term "mental disease" are largely attributable to the fact that the question whether or not a given condition constitutes a mental disease must in each case be resolved by the trier of fact, since the matter of criminal responsibility is a legal, rather than medical, problem.²⁴ The determination may be very simple in a case where all the experts agree, for example, that the accused is suffering from a severe disorder causing him to be psychotic,

²¹ *Id.* at 241, 214 F.2d at 874-75. Most commentators immediately hailed the *Durham* decision. See, e.g., Guttmacher, *The Psychiatrist as an Expert Witness*, 22 U. CHI. L. REV. 325 (1955); Weihofen, *The Flowering of New Hampshire*, 22 U. CHI. L. REV. 356 (1955). But see Wechsler, *The Criteria of Criminal Responsibility*, 22 U. CHI. L. REV. 367 (1955).

²² 94 U.S. App. D.C. at 241, 214 F.2d at 875.

²³ The primary concern of the trier of fact must not be the medical label for the accused's illness, be it disease or defect, nor must it be the psychiatrists' conclusions as to whether or not the illness constitutes a disease or defect in the *Durham* sense. Rather, the courts have stressed the importance of expert testimony designed to acquaint the jury with the *impact* of the illness on the accused's mental processes and behavior controls. See pp. — *infra*. Hence, it can be seen that whether one is suffering from a disease; as distinguished from a defect, is not of ultimate concern.

²⁴ See *Rollerson v. United States*, 343 F.2d 269 (D.C. Cir. 1964); *United States v. Currens*, 290 F.2d 751, 763 (3d Cir. 1961); Zilboorg, *A Step Toward Enlightened Justice*, 22 U. CHI. L. REV. 331, 334 (1955).

and that this disorder is a mental disease.²⁵ Suppose, however, that the psychiatrists are split over the question whether the disorder constitutes a mental disease. It will be seen that this problem does arise when the "disorder" is narcotic addiction.²⁶ How is the jury to reach an intelligent decision when the experts cannot agree? In *Carter v. United States*,²⁷ Judge Prettyman explored this problem and concluded that the trier of fact must be given more than psychiatric labels, such as schizophrenia, paranoia and psychopathy.

Description and explanation of the origin, development and manifestations of the alleged disease are the chief functions of the expert witness. The chief value of an expert's testimony in this field, as in all other fields, rests upon the material from which his opinion is fashioned and the reasoning by which he progresses from his material to his conclusion; in the explanation of the disease and its dynamics, that is, how it occurred, developed, and affected the mental and emotional processes of the defendant²⁸

The judge also added that a "mental disease" must be a "medically recognized illness of the mind,"²⁹ perhaps realizing that he had not entirely laid the problem to rest.

In *Blocker v. United States*,³⁰ decided by the court of appeals in 1961, three judges expressed dissatisfaction with the *Durham* rule as then interpreted. Judge Burger, in a concurring opinion, charged that "mental disease" was a "dangerously vague" term.³¹ His concern was based in part on the fact that Saint Elizabeth's Hospital had recently taken the position that sociopathic or psychopathic personality disturbances amounted to mental disease.³² The jury, given little or no explanation of the ter-

²⁵ Even in this example, however, it can be seen that the trier of fact has little choice but to accept the *legal* conclusions of the experts.

²⁶ For example, in *Horton v. United States*, 115 U.S. App. D.C. 184, 317 F.2d 595 (1963), the sole defense presented at the trial had been insanity based on drug addiction. Two psychiatrists had testified that the defendant had no mental disease, three that the defendant's alleged acts were the product of mental disease, and one that the defendant simply suffered from mental disease. "Thus," said the court, "a jury issue was presented on the issue of criminal responsibility." *Id.* at 185, 317 F.2d at 596.

²⁷ 102 U.S. App. D.C. 227, 252 F.2d 608 (1957).

²⁸ *Id.* at 236, 252 F.2d at 617.

²⁹ *Ibid.*

³⁰ 110 U.S. App. D.C. 41, 288 F.2d 853 (en banc), 36 NOTRE DAME LAW. 581 (1961).

³¹ *Id.* at 49, 288 F.2d at 861 (concurring opinion).

³² In *Campbell v. United States*, 113 U.S. App. D.C. 260, 274, 307 F.2d 597, 611 (1962), Judge Burger, in a dissenting opinion, was similarly concerned with the "expansion" of

minology, could hardly fail to find in accordance with the conclusory opinions of the experts. Judge Burger advocated renewed emphasis in the trial court's charge on the elements of cognition and capacity to control behavior.³³

In 1962, the court of appeals, sitting en banc, decided *McDonald v. United States*,³⁴ which sets forth the current law in the District of Columbia. The court reaffirmed its position that the jury would not be bound by the conclusory opinions of the experts because the experts cannot be permitted the ultimate determination of criminal responsibility. Therefore, stated the court:

[T]he jury should be told that a mental disease or defect includes any abnormal condition of the mind which substantially affects mental or emotional processes and substantially impairs behavior controls. Thus the jury would consider testimony concerning the development, adaptation and functioning of these processes and controls.³⁵

McDonald concerned an allegedly mentally defective defendant with an I. Q. of sixty-eight, who had other mental abnormality. The court noted that the evidence of retarded mentality, by itself, might not have satisfied the "some evidence" standard, but that with the other evidence a jury issue had been presented.³⁶ Regarding the meaning of "some evidence," the court stated that it required more than a scintilla to place the burden of proving sanity on the Government, but that the evidence, for

the term "mental disease" to include the mental illness known as "emotionally unstable personality."

³³ This thesis was further developed by Judge Burger in *Frigillana v. United States*, 113 U.S. App. D.C. 328, 307 F.2d 665 (1962).

³⁴ 114 U.S. App. D.C. 120, 312 F.2d 847 (1962) (en banc).

³⁵ *Id.* at 124, 312 F.2d at 851. The court further explained that its formulation was necessary because a psychiatrist diagnoses a mental condition as a disease or defect for clinical treatment purposes, where criminal responsibility is not at issue.

Chief Judge Bazelon recently reemphasized the necessity for "a full explanation of the dynamics of the defendant's personality," in a case in which the psychiatric testimony had been largely conclusory. *Rollerson v. United States*, 343 F.2d 269 (D.C. Cir. 1964). Bazelon further noted that "the frequent failure to adequately explain and support expert psychiatric opinion threatens the administration of the insanity defense in the District of Columbia." *Ibid.* See also *Jackson v. United States*, — F.2d — (D.C. Cir. 1964) (separate opinion).

³⁶ It should be noted here that, to present evidence sufficient to raise a jury issue of criminal responsibility, only "some evidence" of mental disease or defect need be produced. The defendant need not present any evidence at all of causation or productivity. See *Frigillana v. United States*, 113 U.S. App. D.C. 328, 307 F.2d 665 (1962). It then is incumbent upon the prosecution to prove either that no disease or defect existed, or that there was no productivity.

this purpose, did not need to be so strong as to require a directed verdict. Furthermore, said the court, doubts were to be resolved in the defendant's favor.

Regarding the duty of the trial court to direct a verdict of not guilty by reason of insanity when the Government failed to produce evidence on this issue, the *McDonald* court stated that this depended upon the weight and credibility of the evidence offered by the defendant.³⁷ That is, the mere fact that the defendant has produced "some evidence," and thereby has presented a jury issue, does not necessarily mean that he is entitled to a directed verdict, even in the absence of countervailing evidence. Whether the Government must adduce testimony of sanity to avoid a directed verdict would seem to depend on factors such as the severity of the mental illness described and whether or not the defendant has offered expert testimony.³⁸

A recent decision by the United States Court of Appeals for the District of Columbia Circuit, *Heard v. United States*,³⁹ held that "a showing of narcotics addiction, without more, does not constitute 'some evidence' of mental disease or 'insanity' and does not raise the issue of criminal responsibility so as to require giving the *Durham-McDonald* instruction."⁴⁰ The court suggested that evidence of deprivation of narcotics at the time of the alleged offense would be evidence of impairment of behavior controls, and would require that the instruction be given. In his dissent, Judge Wright indicated that the government psychiatrists had testified that the defendant's addiction would affect his mental and emotional processes and his behavior controls. Therefore, he reasoned, "some evidence" of mental illness had been presented, notwithstanding the experts' conclusory opinions that the defendant did not suffer from mental disease or defect. The validity of the majority holding will be examined subsequently. But considering the number of times the court of appeals has said in dictum that "the defense of insanity based on drug addiction generally presents a jury issue as

³⁷ 114 U.S. App. D.C. at 123, 312 F.2d at 850. Note that the production of "some evidence" of insanity does not nullify the presumption of sanity, which, according to *Davis v. United States*, 160 U.S. 469 (1895), remains in every case and is to be considered, together with all the evidence, by the trier of fact. *Keys v. United States*, No. 18786, D.C. Cir., April 29, 1965.

³⁸ Although the defendant invoking the insanity defense is well advised to offer expert testimony, he may be able to get to the jury without it. See, e.g., *Alexander v. United States*, 115 U.S. App. D.C. 303, 318 F.2d 274 (1963).

³⁹ —F.2d—(D.C. Cir. 1964).

⁴⁰ —F.2d at —.

to criminal responsibility,"⁴¹ it would seem that the *Heard* decision should not be interpreted broadly.

The meaning of the word "product" in the *Durham* formula has also caused much difficulty over the years. The principal problem has been that, given mental illness, it is almost always impossible for a psychiatrist to state that the illness *did not* produce the crime.⁴² The witness therefore either answers affirmatively or declines to express an opinion on this subject, both of which results are fatal to the Government, which has the burden of proving the negative beyond a reasonable doubt.⁴³ In *Carter v. United States*,⁴⁴ Judge Prettyman articulated a "but for" test for determining productivity under *Durham*. He stated that:

there must be a relationship between the disease and the act, and that relationship, whatever it may be in degree, must be, as we have already said, critical in its effect in respect to the act. . . . [By this we mean] that the facts concerning the disease and the facts concerning the act are such as to justify reasonably the conclusion that "But for the disease the act would not have been committed."⁴⁵

This apparently means that the Government must prove that the defendant would have committed the crime even had he not been mentally ill. This particular conclusion is one which psychiatrists are apparently quite hesitant to reach. Judge Prettyman suggested, however, that if the expert testimony is directed toward an explanation of the dynamics of the defendant's mental condition and the effect of that condition on the defendant's mental or emotional processes and behavior controls, the jury will have been given enough information to decide the productivity question with reasonable accuracy.⁴⁶

By way of brief summary, a defendant in the District of Columbia need introduce only more than a scintilla of evidence of mental disorder to create a jury issue of criminal responsibility. He will have to offer sub-

⁴¹ See note 14 *supra* and accompanying text. This statement was also repeated in *Castle v. United States*, —F.2d—, —n.5 (D.C. Cir. 1964), and in *Jackson v. United States*, —F.2d—, —(D.C. Cir. 1964) (separate opinion of Bazelon, C.J.).

⁴² See *Frigillana v. United States*, 113 U.S. App. D.C. 328, 307 F.2d 665 (1962), where not one of seven defense psychiatrists could offer an unequivocal opinion on this question. Judge Burger emphasized this uncertainty and quoted ROCHE, *THE CRIMINAL MIND* 270 (1958), to the effect that the "product" question can be answered only affirmatively or not at all.

⁴³ The prosecution, of course, may sustain its burden by proving beyond a reasonable doubt that no mental disease or defect existed at the time in question.

⁴⁴ 102 U.S. App. D.C. 227, 252 F.2d 608 (1957).

⁴⁵ *Id.* at 236, 252 F.2d at 617.

⁴⁶ *Ibid.*

stantial evidence, however, to obtain a directed verdict even in the absence of rebuttal testimony. Assuming the Government successfully avoids the directed verdict, the jury will be told that, unless they are satisfied beyond a reasonable doubt (1) that the accused did not suffer from mental disease or defect at the time of the offense, *or* (2) that the crime was not produced by mental disease or defect, they cannot return a verdict of guilty. They will also be told that the terms "mental disease or defect" include any mental abnormality which substantially affects mental or emotional processes and substantially impairs behavior controls, and that the term "product" denotes that the act would not have been committed but for the abnormality.

It is interesting to compare these criteria with the proposed standards for criminal responsibility contained in the most recent draft of the American Law Institute's *Model Penal Code*, which states:

(1) A person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality [wrongfulness] of his conduct or to conform his conduct to the requirements of law.

(2) As used in this Article, the terms "mental disease or defect" do not include an abnormality manifested only by repeated criminal or otherwise antisocial conduct.⁴⁷

In the comments to this section of the model code,⁴⁸ the drafters rationalize their rejection of *M'Naghten*, even when supplanted by the "irresistible impulse" test, in much the same fashion Judge Bazelon did in *Durham*.⁴⁹ They suggest that the impairment of capacity to control be-

⁴⁷ MODEL PENAL CODE § 4.01 (Proposed Official Draft 1962).

⁴⁸ MODEL PENAL CODE § 4.01 (Tent. Draft No. 4, 1955).

⁴⁹ The "irresistible impulse" test had been adopted in the District of Columbia in *Smith v. United States*, 59 App. D.C. 144, 36 F.2d 548 (1929), where the court stated that an uncontrollable impulse in the mind which overrides reason and judgment and obliterates the sense of right and wrong to the extent that one is deprived of the power to choose between right and wrong amounts to legal insanity. In *Durham*, the court suggested that its new standard would encompass not only sudden impulses but also impulses following brooding or reflection which might not have qualified under the *Smith* case.

Since the *Durham* decision, the jury may be permitted to consider the question of irresistible impulse, but the ultimate issue must always be framed in terms of the *Durham-McDonald* standards. *Misenheimer v. United States*, 106 U.S. App. D.C. 220, 271 F.2d 486 (1959). However, if properly instructed that a mental disease is any abnormal mental condition which substantially affects mental processes and substantially impairs behavior controls, the jury should have no difficulty finding mental illness in all instances where formerly it would have found an irresistible impulse. The new test requires only substantial impairment of behavior controls, whereas the *Smith* formulation seemed to require a total lack of power to choose between right and wrong.

havior is no less important in this determination than the impairment of cognition. They also wish to include acts over which the individual had no control but which would not fall within the ambit of the "irresistible impulse" test because they may not have been sudden and spontaneous.⁵⁰ They reject the *Durham* formulation, however, because of the ambiguity of the term "product," suggesting that "if interpreted to lead to irresponsibility unless the defendant would have engaged in the criminal conduct even if he had not suffered from the disease or defect, it [the term] is too broad"⁵¹ Their model formulation employs a criterion of causation which resembles a "substantial factor" test.⁵²

The only real difference between the two formulations, then, would seem to be that *Durham* purports to exclude mental conditions which do not result in substantial incapacity to control behavior and recognizes slight degrees of causation, whereas the ALI formulation utilizes the element of substantial incapacity to control behavior on the causation question, and merely excludes those diseases and defects whose only symptomatology is repeated antisocial conduct. Considering that the question of criminal responsibility is usually resolved by the jury, it would seem that this is not a difference of substance.⁵³ A growing number of jurisdictions have adopted tests resembling the ALI formulation.⁵⁴

⁵⁰ The drafters knew that "the application of the principle [of substantial capacity to control conduct] will call, of course, for a distinction between incapacity, upon the one hand, and mere indisposition on the other. Such a distinction is inevitable in the application of a standard addressed to impairment of volition. We believe that the distinction can be made." MODEL PENAL CODE 158 (Tent. Draft No. 4, 1955).

⁵¹ *Id.* at 159.

⁵² Professor Wechsler suggests:

If my questions about the ambiguities involved in "product" are good, and I think they are, I do not think the concept can be used at all. In short, I think we must insist that it is only when causality inheres in the substantial impairment of capacity that irresponsibility can be acknowledged to obtain.

Id. at 188. This is an excerpt from a fascinating and revealing correspondence between Prof. Wechsler and Dr. Manfred Guttmacher regarding the criteria for criminal responsibility to be employed in the *Model Penal Code*. *Id.* at 182-92.

⁵³ In dictum, the United States Court of Appeals for the Eighth Circuit recently suggested that it would not disapprove any jury charge "if the charge appropriately embraces and requires positive findings as to 3 necessary elements, namely, the defendant's *cognition*, his *volition*, and his *capacity to control* his behavior." *Dusky v. United States*, 295 F.2d 743, 759 (8th Cir. 1961), *cert. denied*, 368 U.S. 998 (1962); see *Feguer v. United States*, 302 F.2d 214, 242-45 (8th Cir. 1962).

⁵⁴ See, e.g., *United States v. Currens*, 290 F.2d 751 (3d Cir. 1961), where Chief Judge Biggs rejected the *M'Naghten* formulation and adopted a new test for criminal responsibility for the Third Circuit. He stated: "The jury must be satisfied that at the time of com-

Two important principles to be gleaned from the foregoing discussion will have a decisive bearing on the relationship of narcotic addiction to criminal responsibility. The first is that both of these modern standards emphasize the element of capacity to control behavior or to conform behavior to prescribed standards. If a defendant, because of mental disease, defect or abnormality, substantially lacked this capacity at the time he acted, his act was not a crime. Secondly, it cannot be overemphasized that criminal responsibility is always a legal, not a medical, determination. The law must provide the framework and the controlling criteria to allow the trier of fact intelligently to assess the medical testimony and to arrive at the proper conclusion in accordance with traditional legal principles. Perhaps the only flaw in the *Durham* formulation, prior to *McDonald*, was that it failed to provide these criteria and therefore tended to place the difficult problems of criminal responsibility in the unreceptive hands of the psychiatrists.

THE ADDICTION DISEASE

Before examining the direct effects of addiction on the behavior of the addict, it will be helpful to note that most narcotic addicts suffer from underlying mental disorders that predated and probably contributed to their use of narcotics. In some instances, these disorders will in themselves negate criminal responsibility. Among the many attempts which have been made to classify the personality types into which addicts can be placed, the following classification appears to be simplest and most complete:

1. Normal individuals accidentally addicted;
2. Individuals with personality disorders of all types (formerly called psychopaths);

mitting the prohibited act the defendant, as a result of mental disease or defect, lacked substantial capacity to conform his conduct to the requirements of the law which he is alleged to have violated." *Id.* at 774; see *Dusky v. United States*, *supra* note 53. In *Manual on Jury Instructions in Federal Criminal Cases*, 33 F.R.D. 523, 560 (1964), promulgated by the United States District Court for the Northern District of Illinois, the following charge on insanity is suggested:

The defendant has interposed insanity as a defense. The law presumes that a defendant is sane. This presumption is rebuttable. Where a defendant introduces some evidence that he had a mental disease or defect at the time of the commission of the crime charged, the prosecution must establish beyond a reasonable doubt that defendant did not have a mental disease, or that despite the mental disease he had the capacity either to know the criminality of his conduct, or to conform his conduct to the requirements of the law.

The issue of whether or not a mental disease or defect existed at the time of the commission of the crime must be determined by the jury on the basis of all evidence, lay and expert, and the presumption of sanity.

3. Psychoneurotic individuals of all types;
4. Narcotic addicts with associated psychoses.⁵⁵

Normal individuals accidentally addicted make up a very small percentage of the total addict population.⁵⁶ These are the individuals who have received narcotics over an extended period of treatment for physical illness, and who remain addicted thereafter.⁵⁷ Noyes and Kolb suggest that "probably all persons who acquire addiction in this manner have some fundamental emotional problem that caused them to continue the use of drugs beyond the period of medical need,"⁵⁸ the theory being that the controlled quantities of narcotics administered in the treatment setting will not produce or lead to addiction unless the individual has emotional or personality difficulties which give rise to a psychological need.⁵⁹

⁵⁵ See Felix, *An Appraisal of the Personality Types of the Addict*, 100 AM. J. PSYCHIATRY 462, 465 (1944). The more traditional Kolb classification of personality types of addicts listed six categories: (1) normal individuals accidentally addicted; (2) individuals with psychopathic diathesis or predisposition; (3) psychoneurotic individuals of all types; (4) individuals without psychosis, but with psychopathic personalities of all types; (5) addicts with inebriate personalities; and (6) addicts with associated psychoses. See Kolb & Ossensfort, *The Treatment of Drug Addicts at the Lexington Hospital*, 31 SO. MED. J. 914, 916 (1938). Felix maintained that category (5) would in all events be included in either category (2), (3) or (4). Felix, *Some Comments on the Psychopathology of Drug Addiction*, 23 MENTAL HYGIENE 567, 570 (1939). He later concluded that category (2), psychopathic diathesis, is often a catchall classification, and that individuals so classified should be placed in either the psychotic, psychoneurotic, or psychopathic (sociopathic) classification. 100 AM. J. PSYCHIATRY at 463. A more recent article discusses Felix's four classifications with approval, and concludes that Kolb's psychopathic diathesis type is simply a personality disorder group with less severity than the true psychopath (or sociopath, in modern terminology). Vogel, Isbell & Chapman, *Present Status of Narcotics Addiction*, 138 A.M.A.J. 1019, 1021 (1948). See also WIKLER, *OPiate ADDICTION* 4 (1953); MAURER & VOGEL, *NARCOTICS AND NARCOTIC ADDICTION* 82 (2d ed. 1962).

⁵⁶ HOCH & ZUBIN, *PROBLEMS OF ADDICTION AND HABITUATION* 2-3 (1958); MAURER & VOGEL, *op. cit. supra* note 55, at 82-83; MARIE NYSWANDER ROBINSON, *THE DRUG ADDICT AS A PATIENT* 62 (1956); Cameron, *Addiction—Current Issues*, 120 AM. J. PSYCHIATRY 313, 314 (1963); Winick, *Narcotics Addiction and Its Treatment*, 22 LAW & CONTEMP. PROB. 9, 21 (1957).

⁵⁷ These individuals are addicted in the sense that they have developed physical dependence on the drug; however, they develop little or no psychological dependence and, therefore, contrary to popular thinking, are not likely to relapse after undergoing withdrawal. MAURER & VOGEL, *op. cit. supra* note 55, at 83. In these days of strict narcotics control, this category is much less significant than it was thirty or forty years ago. Maurer and Vogel note that, of 1,000 recent admissions to the Lexington Hospital, only five per cent were considered "medical addicts." *Ibid.*

⁵⁸ NOYES & KOLB, *MODERN CLINICAL PSYCHIATRY* 475 (6th ed. 1963).

⁵⁹ Some patients are, of course, unavoidably addicted during treatment, as, for example, a terminal cancer patient, but these individuals are not considered here.

The great majority of addicts present some form of personality disturbance,⁶⁰ which illness often is manifested by a pattern of antisocial behavior, rather than by observable mental symptoms.⁶¹ These individuals, because of an unsatisfactory adjustment, find themselves unable to attain the objects of fundamental drives such as security, sex and power. The resultant inner tensions and frustrations produce various amounts of hostility, immaturity and aggressiveness,⁶² which are assuaged by the artificial pleasure and peace afforded by the drug. A substantial number of these individuals are diagnosed as having inadequate personalities,⁶³ which "are characterized by inadequate response to intellectual, emotional, social and physical demands."⁶⁴ They display "inadaptability, ineptness,

⁶⁰ CHEIN, GERARD, LEE & ROSENFELD, *THE ROAD TO H*, at 14, 194 (1964); NOYES & KOLB, *op. cit. supra* note 58, at 474; MARIE NYSWANDER ROBINSON, *op. cit. supra* note 56, at 62-63; Meiselas, A Report of Some Early Clinical Experiences from the New York State Department of Mental Hygiene's Narcotic Research Unit, at 4, presented to the National Research Council Committee on Drug Addiction and Narcotics, New York City, Jan. 29, 1962; Clausen, *Social and Psychological Factors in Narcotics Addiction*, 22 *LAW & CONTEMP. PROB.* 34, 43-44 (1957); Vogel, Isbell & Chapman, *supra* note 55, at 1021; Winick, *supra* note 56, at 20; Editorial, 184 *A.M.A.J.* 962 (1963).

Apparently, the British statistics are similar. Lady Frankau, a London psychiatrist who has treated some 500 addicts, has been quoted as follows: "The only way to help the addict is to treat his underlying problems. Every one I have treated has had a personality disorder. These are inadequate people, immature and unstable, with a low threshold for pain and unable to bear their frustrations." Samuels, *The British Way With the "Junkie"*, *N.Y. Times*, Oct. 18, 1964, § 6 (Magazine), pp. 37, 134.

⁶¹ AMERICAN PSYCHIATRIC ASSOCIATION, *DIAGNOSTIC AND STATISTICAL MANUAL, MENTAL DISORDERS 34* (1952) [hereinafter cited as *DIAGNOSTIC AND STATISTICAL MANUAL*]. This does not mean, however, that a pattern of antisocial behavior justifies a diagnosis of personality disorder which, in turn, excuses the antisocial behavior. Cameron has ably pointed out that sociopathy is a diagnosable clinical syndrome, and that it can be recognized by a combination of most of the following positive findings, which are the hallmarks of sociopathy:

1) an inability to put off present pleasure for future gain; 2) lack of aim and of foresight; 3) failure to learn from experience; 4) impulsiveness; 5) egocentricity; 6) a lack of lasting emotional rapport with others; 7) a lack of sympathy; 8) general immaturity; and 9) little regulatory influence of intellect on behavior. Please note that many criminals do not show at least six of these nine criteria (1, 2, 3, 4, 8, and 9). Also note that antisocial behavior is not listed since it really is not a medical symptom in the true sense.

Cameron, *Is Sociopathy (Psychopathy) a Sufficient Mental Abnormality to Support a Finding of Not Guilty by Reason of Insanity?*, presented to the Section on Judicial Administration, American Bar Ass'n, Chicago, Ill., Aug. 10, 1963.

⁶² Felix, *Some Comments on the Psychopathology of Drug Addiction*, 23 *MENTAL HYGIENE* 567, 571-73 (1939). See generally NOYES & KOLB, *op. cit. supra* note 58, at 58-65, 458-71.

⁶³ COUNCIL ON MENTAL HEALTH, *REPORT ON NARCOTIC ADDICTION 10*, adopted by the AMA in 1957 and published in *NARCOTICS ADDICTION* (AMA pub. 1963) [hereinafter cited as *AMA REPORT ON NARCOTIC ADDICTION*]; Cameron, *supra* note 56, at 314.

⁶⁴ *DIAGNOSTIC AND STATISTICAL MANUAL* 35.

poor judgment, lack of physical and emotional stamina, and social incompatibility."⁶⁵ With respect to legal insanity apart from their addiction, no general rule regarding persons with personality disorders can be formulated. Many such individuals have been acquitted by reason of insanity,⁶⁶ but many undoubtedly do not present a mental disease in the *McDonald* sense. To what extent the added factor of addiction should tip the balance in favor of exculpation will be considered later.

Psychoneurotic individuals, who account for a substantial minority of the addict population,⁶⁷ manifest anxiety resulting from repressed emotions, aggressive impulses and external threats or losses. Unlike psychotics, these individuals do not suffer from gross distortions of reality, delusions or hallucinations; rather, many of them adopt various defense mechanisms such as sickness, phobias, compulsive behavior and insomnia which enable them to believe that their failures are simply the result of their illness, without which they would be able to adjust and compete successfully in life.⁶⁸ For these people narcotic drugs afford relief from these sicknesses and phobias and also from psychic tension and anxiety. They may believe that continued use of the drug is necessary for their physical health. This mental illness is more severe than personality disturbance, and, even apart from drug use, its victims are more likely to be found not criminally responsible for their antisocial acts.

Drug addicts with associated psychoses make up a small fraction of the addict population,⁶⁹ and will be given no further consideration. They have severe mental disorders, and are hardly ever criminally responsible for their antisocial acts, irrespective of narcotic addiction.

Although the foregoing discussion suggests that most addicts suffer from either personality disorders or psychoneuroses, most psychiatrists agree

⁶⁵ *Ibid.*

⁶⁶ See, e.g., *Williams v. United States*, 114 U.S. App. D.C. 135, 312 F.2d 862 (1962) (sociopathic personality disturbance sufficient to raise jury issue but not to compel judgment of acquittal); *Campbell v. United States*, 113 U.S. App. D.C. 260, 307 F.2d 597 (1962) (emotionally unstable personality); *Blocker v. United States*, 110 U.S. App. D.C. 41, 288 F.2d 853 (1961) (en banc) (sociopathic personality disturbance).

⁶⁷ See HOCH & ZUBIN, *op. cit. supra* note 56, at 2-3; AMA REPORT ON NARCOTIC ADDICTION 10; Felix, *An Appraisal of the Personality Types of the Addict*, 100 AM. J. PSYCHIATRY 462, 463 (1944); Wikler & Rasor, *Psychiatric Aspects of Drug Addiction*, 14 AM. J. MED. 566 (1953).

⁶⁸ Felix, *supra* note 67, at 463-64. See generally NOYES & KOLB, *op. cit. supra* note 58, at 419-56.

⁶⁹ See Vogel, Isbell & Chapman, *supra* note 55, at 1021; Wikler & Rasor, *supra* note 67, at 566.

that addicts today usually possess mixed traits and symptoms. "The majority of addicts . . . do not fall into clear-cut nosological entities, but rather present mixtures of traits of the kind found in neuroses, character [personality] disorders, and inadequate personalities. This is a general finding in addiction."⁷⁰ No two addicts will present similar symptomatology, but most addicts suffer from some mental illness which can lead to a genuine psychological need for narcotics. This is not to say that most individuals with mental illness become addicted; the point is that these personality types are likely to use narcotic drugs to the point of addiction once they are introduced to the drug.⁷¹ They are addiction prone. It has been stated that an addict is

an inadequately adjusted individual, not radically different from his non-addicted fellows, who has at some time discovered that drugs either dulled the sense of discomfort produced by his difficulties, or gave him a subjective feeling of mastery over his situation. In either case he experienced a release and emotional uplift which compensated for the attitude of society toward him.⁷²

In this context, the *Brown* decision⁷³ takes on added meaning, for it cannot be questioned that the fact of addiction is in most instances symptomatic of mental illness.⁷⁴

⁷⁰ AMA REPORT ON NARCOTIC ADDICTION 10; see AMERICAN BAR FOUNDATION, NARCOTICS AND THE LAW 22 (1962).

⁷¹ Maurer and Vogel suggest:

While there is much more to drug addiction than simply classifying addicts as poorly adjusted people who seek a compensation for their own weaknesses, the personality defect is clearly manifest in those who are inveterate addicts, and the capacity of opiates to give the individual the illusion that he has mastery over life situations about which he can do little or nothing, coupled with the power these drugs have of giving intense physical and emotional pleasure, may make them irresistible to addiction-prone people. MAURER & VOGEL, *op. cit. supra* note 55, at 83.

⁷² Felix, *supra* note 67, at 465. Another authority describes the addict as a person unable to adjust to society who needs immediate gratification of his needs and wants to escape unbearable tension, and, "simultaneously confronted with the irresistible need for immediate gratification and the ungratifying environment, it is inevitable that he will feel justified in employing any measure to rectify his deprivation." Raskin, A Suggested Approach to the Problem of Narcotic Addiction, presented to the Division of Medical Sciences, National Research Council, National Academy of Sciences, Detroit, Mich., April 8, 1960. Menninger describes an "addictive personality," which is susceptible to "chemically induced escapes from reality . . . [which] clearly represent a partial ego failure." MENNINGER, *THE VITAL BALANCE* 210 (1963).

⁷³ *BROWN v. United States*, 331 F.2d 822 (D.C. Cir. 1964), discussed pp. 1019-20 *supra*.

⁷⁴ See MAURER & VOGEL, *op. cit. supra* note 55, at 82; NOYES & KOLB, *op. cit. supra* note 58, at 474-75; DIAGNOSTIC AND STATISTICAL MANUAL 39; PRESIDENT'S REPORT 86; NARCOTIC DRUG STUDY COMM'N, NEW JERSEY LEGISLATURE, INTERIM REPORT FOR 1963, at 71 (1964) [hereinafter cited as N.J. REPORT]; *Mental Health Monograph No. 2*, NARCOTIC DRUG

It is also noteworthy that narcotic addiction is most prevalent in large metropolitan areas of urban blight and gross socioeconomic deprivation. The Federal Bureau of Narcotics has estimated that, as of December 31, 1962, seventy-nine per cent of the nation's known addicts were to be found in ten cities.⁷⁵ Fifty-five per cent of the addicts are Negroes, eighteen per cent Puerto Ricans and Mexicans.⁷⁶ However, these are the groups that are concentrated in the economically deprived areas of our large cities, and who are educationally deprived as well. It has been shown that areas of Negro and Puerto Rican residence that are less economically deprived have a much lower rate of drug use.⁷⁷ In these metropolitan areas

ADDICTION 5-6 (Pub. Health Serv. Pub. No. 1021, 1963); AMA REPORT ON NARCOTIC ADDICTION 10; Ausubel, *The Case for Compulsory Closed Ward Treatment of Narcotic Addiction*, 31 F.R.D. 58, 69-70 (1963); Cameron, *supra* note 56, at 314; Chapman, *Methods of Treatment and Management of Drug Addiction*, in NARCOTIC DRUG ADDICTION PROBLEMS 70, 71-73 (Pub. Health Serv. Pub. No. 1050, 1963); Chein & Rosenfeld, *Juvenile Narcotics Use*, 22 LAW & CONTEMP. PROB. 52, 60 (1957); Lowry, *Hospital Treatment of the Narcotic Addict*, Fed. Prob., Dec., 1956, pp. 44-45; Meiselas, *supra* note 60, at 4.

⁷⁵ BUREAU OF NARCOTICS, U.S. TREASURY DEP'T, TRAFFIC IN OPIUM AND OTHER DANGEROUS DRUGS 58 (1963). The breakdown was as follows:

New York, N.Y.	21,566 addicts
Chicago, Ill.	6,972 "
Los Angeles, Calif.	3,183 "
Detroit, Mich.	1,780 "
Dist. of Col.	918 "
San Francisco, Calif.	655 "
Newark, N.J.	652 "
Philadelphia, Pa.	615 "
Oakland, Calif.	482 "
San Antonio, Texas	477 "
TOTAL	37,300 "
TOTAL ADDICTS IN NATION (REPORTED)	47,489 "

The FBN estimates that there are 60,000 addicts in the nation today, as compared with an estimated 200,000 during World War I. BUREAU OF NARCOTICS, U.S. TREASURY DEP'T, PREVENTION AND CONTROL OF NARCOTIC ADDICTION 7 (1964). As might be expected, drug use within a city is concentrated in areas of socioeconomic deprivation. In New York, for instance, it is estimated that 15% of the city's area, which contains 29% of the population, accounts for 83% of the city's drug use. CHEIN, GERARD, LEE & ROSENFELD, *op. cit. supra* note 60, at 39, 52.

⁷⁶ BUREAU OF NARCOTICS, U.S. TREASURY DEP'T, TRAFFIC IN OPIUM AND OTHER DANGEROUS DRUGS 54 (1963).

⁷⁷ Clausen, *supra* note 60, at 38. Clausen notes that, within the cities having large addict populations, the narcotics use is concentrated in areas of low socioeconomic status and urban blight. These are also the areas with the highest delinquency and crime rates. He concludes that life in the urban slum is conducive to drug use. *Id.* at 41-43; see Chein, *The Status of Sociological and Social Psychological Knowledge Concerning Narcotics*, in NARCOTIC DRUG ADDICTION PROBLEMS 146, 152 (Pub. Health Serv. No. 1050, 1963). The recent New Jersey report listed 73% of that state's addicts as nonwhite persons, and concluded:

with high addict populations, many persons are exposed to narcotics without ever becoming addicted, "indicating the presence of a specific and potentially identifiable difference among individuals that separates those who will become addicted and those who will not."⁷⁸ It would seem that the disproportionate number of addicts in cities such as New York, Chicago, Los Angeles and Washington is due partially to the ease of access in these areas. There are undoubtedly many addiction-prone individuals in rural areas that have fortunately never been exposed to narcotics. It would also seem that localities characterized by socioeconomic deprivation and urban blight would tend to spawn addiction-prone individuals. Unstable family structures, particularly those lacking a strong father figure, are conducive to psychic problems and to narcotic addiction,⁷⁹ and these families are often encountered in the urban slum. Furthermore, the inability of many individuals in these areas ever to attain even modest goals would seem to produce frustration and addiction proneness.

The individual may be introduced to narcotics in many ways, but, contrary to popular belief, he is not usually given his first dose by a

"Since non-whites tend to be found among the lower socio-economic classes in the so-called 'core cities,' it seems reasonable to assume that narcotic violations are related to disadvantaged social position in large urban areas." N.J. REPORT 35.

⁷⁸ Larimore, *Medical Views on the Narcotic Problem*, 31 F.R.D. 53, 80, 83 (1963). Professor Chein notes: "[W]e know of individuals who go on using a drug like heroin for several years on a more or less regular weekend basis and then, apparently without difficulty, quit." Chein, *supra* note 77, at 148.

Another unexplained phenomenon which must be considered in this context is the age factor in narcotics use. As of December 31, 1962, 3.4% of the nation's addicts were under 21 years of age, 48.6% were 21-30, 37.0% were 31-40, and only 11.0% were over 40. BUREAU OF NARCOTICS, U.S. TREASURY DEP'T, *op. cit. supra* note 76, at 55. There is much evidence that this concentration of addicts in the 21-30 age bracket is not a recent phenomenon. See AMA REPORT ON NARCOTIC ADDICTION 9. A 1936-1937 study of 1,036 addict-patients admitted to the Lexington Hospital revealed that 16.5% had begun the use of drugs before age 19. See Isbell, *Clinical Research on Addiction in the United States*, in NARCOTIC DRUG ADDICTION PROBLEMS 114, 125 (Pub. Health Serv. Pub. No. 1050, 1963). It is apparently not known at this time whether there is a physiological or psychological explanation for this decrease in addiction after age 40, or whether it simply reflects the toll of death and long-term imprisonment. PRESIDENT'S REPORT 22.

⁷⁹ Chein, *supra* note 77, at 152-53; Fort, *Heroin Addiction Among Young Men*, 17 PSYCHIATRY 251, 254-55 (1954); Wikler & Rasor, *supra* note 67, at 567. The latter authors describe a psychoanalytic formulation which suggests that male addicts whose childhood was characterized by the absence of a consistently strong father figure often suffer from arrested or regressed psychosexual development. In them, oral cravings have dominance over genital pleasures, and this can lead to frustration, hostility and the addiction-prone personality.

"pusher." Rather, his introduction is usually through a friend or acquaintance,⁸⁰ although many addicts first "discovered" narcotics in the course of medical treatment, and some undoubtedly did initially succumb to the importunings of the fabled dope peddler. Of great importance is the fact that narcotic use does not inevitably or even usually lead to addiction unless the individual is addiction prone. The relatively normal individual will probably not become addicted after having used a narcotic drug;⁸¹ indeed, it appears that many persons are able to use highly addicting drugs periodically over long periods of time without ever becoming addicted.⁸² This is because the initial physiological effects of the drug are simply not irresistible in a normal individual,⁸³ although they may be pleasurable. The addiction-prone type, however, experiences much more than physical gratification from his first experience with narcotics. He develops a psychological need or craving which he is probably powerless to ignore,⁸⁴ and it is this psychological dependence, also called habituation, which renders his subsequent addiction virtually inevitable. When experiencing the effects of the drug, he finds that the frustration and anxiety of his daily existence mysteriously evaporates, that is, he obtains relief from his particular emotional difficulties or symptoms. In many cases, this means relief from anx-

⁸⁰ CHEIN, GERARD, LEE & ROSENFELD, *op. cit. supra* note 60, at 12; AMERICAN BAR FOUNDATION, NARCOTICS AND THE LAW 28-29 (1962); *Mental Health Monograph No. 2, supra* note 74, at 6; PRESIDENT'S REPORT 4; REPORT ON NARCOTIC ADDICTION 13; Fort, *supra* note 79, at 252.

⁸¹ See note 78 *supra*. Chapman states:

Information coming to us from various sources indicates that all users of drugs do not become addicts. Some may use it only on week ends as part of group behavior. Others take an occasional shot during the week or at irregular intervals and never become addicted.

Chapman, *Drug Addiction: The General Problem*, Fed. Prob., Sept., 1956, p. 43.

It has been noted that normal persons tend initially to react *negatively* to drugs, the experience being a rather distasteful one. These persons may become physically addicted during medical treatment, but, when introduced to drugs casually, do not usually continue to use them. This is because they do not experience the intense pleasure or euphoria which the addiction-prone person associates with use of the drug. MAURER & VOGEL, *op. cit. supra* note 55, at 73. Maurer and Vogel suggest that "intensity of the pleasure from opiates seems to vary with the degree to which the individual may be called a neurotic or a psychopath . . ." *Id.* at 74.

⁸² See notes 78 & 81 *supra*.

⁸³ See note 81 *supra*.

⁸⁴ MAURER & VOGEL, *op. cit. supra* note 55, at 73-75. The intensity of the pleasure the individual derives from the drug seems to be a function of the severity of the underlying mental disorder. See note 81 *supra*. The intensity of the psychological craving will, in turn, be related to the amount of pleasure obtained from use of the drug. See NOYES & KOLB, *op. cit. supra* note 58, at 474; Cameron, *supra* note 56, at 314-15.

iety associated with fear of hunger, pain and sexual urges, which are basic needs that the addiction-prone person may not be able to gratify in socially acceptable ways.⁸⁵ In addition, this type of individual apparently experiences an intense euphoria, a sustained emotional uplift which seems to be related to the capacity of the drug to satisfy basic needs.⁸⁶ These pleasurable phenomena lead to an irresistible craving. The addiction-prone person has discovered something he may well have been searching for all his life. Habituation is a continuing psychic need or craving for this pleasure, and should not be confused with the physiological sensations derived from administration of the drug. Psychiatrists regard psychological dependence as the most important characteristic of addiction.⁸⁷ They conclude that the psychological meaning of the drug to the addict, that is, its capacity to reduce frustration and anxiety and to induce a feeling of pleasure and mastery, is far more significant than the physiological effects of the drug.⁸⁸ One authority explains that "physical dependence is merely a complication."⁸⁹ The exact meaning of a drug to a given addict will be closely related to the nature and intensity of his personality problems; hence, psychological dependence is often said to be a function of the underlying mental disorder.⁹⁰ It is for this reason that normal individuals do not usually become addicted. Cameron has said: "Without such a psychological 'need' there would be little, if any, addiction."⁹¹

⁸⁵ WIKLER, *op. cit. supra* note 55, at 54-55; CHEIN, GERARD, LEE & ROSENFELD, *op. cit. supra* note 60, at 227-28. This symptom relief has also been called negative pleasure. See, e.g., KOLB, *DRUG ADDICTION: A MEDICAL PROBLEM* 93 (1962); Wikler & Rasor, *supra* note 67, at 566.

⁸⁶ Kolb termed this sustained emotional uplift "positive pleasure," and suggested that it represents a form of relief from fundamental or permanent emotional problems. KOLB, *op. cit. supra* note 85, at 93. Others reject the idea of positive pleasure, reasoning that euphoria associated with drug use is simply a product of symptom relief. See, e.g., CHEIN, GERARD, LEE & ROSENFELD, *op. cit. supra* note 60, at 14, 228. Psychiatrists are agreed, however, that the pleasure felt by the potential addict is intense, whatever its exact psychological foundation.

⁸⁷ E.g., CHEIN, GERARD, LEE & ROSENFELD, *op. cit. supra* note 60, at 6; Vogel, Isbell & Chapman, *supra* note 55, at 1020.

⁸⁸ See Chapman, *Methods of Treatment and Management of Drug Addiction*, in *NARCOTIC DRUG ADDICTION PROBLEMS* 70, 71 (Pub. Health Serv. Pub. No. 1050, 1963).

⁸⁹ Isbell, *supra* note 78, at 128-29.

⁹⁰ KOLB, *op. cit. supra* note 85, at 95; see WIKLER, *op. cit. supra* note 55, at 54-55.

⁹¹ Cameron, *supra* note 56, at 315. In *Mental Health Monograph No. 2*, *supra* note 74, at 5, the Public Health Service asserts: "By and large, the people who become addicts are those for whom drugs serve a special need, which can be summed up as the relief of pain. Last century the pain that led to addiction was often physical; today it is mainly psychic." The monograph goes on to state that today's addicts obtain relief from anxiety, tension,

As the addiction-prone individual continues to use the narcotic drug regularly, he soon discovers that the same dose fails to produce the original euphoric effect, and that from time to time he must increase the dose to produce the desired effect. This phenomenon is called "tolerance."⁹² The average addict builds up tolerance to a dosage of narcotics greater than that amount sufficient to kill an average person.⁹³ After prolonged administration of an opiate, physical dependence⁹⁴ manifests itself. The user finds that he must continue to administer the drug regularly in order to avoid the withdrawal or abstinence syndrome. He is "hooked." He must have drugs not only to produce pleasure but also to avoid pain. It has been said that physical dependence "leads to continuity of intoxication with resultant subservience of all phases of the addict's life to the one aim of obtaining and maintaining a constant supply of the drug."⁹⁵ He is compelled to obtain it and thus to prevent the withdrawal syndrome, which, in the

feelings of inadequacy and other emotional problems by resorting to drugs. The report concludes that addicts have personality problems, and that addiction is a symptom of these problems.

⁹² MARIE NYSWANDER ROBINSON, *op. cit. supra* note 56, at 92; see Severs & Woods, *The Phenomena of Tolerance*, 14 AM. J. MED. 546 (1953), who state: "It is probably true that tolerance ultimately becomes of such a magnitude that the effect of the initial dose cannot be reproduced by excessive doses." *Ibid.*

⁹³ See AMA REPORT ON NARCOTIC ADDICTION 11; Cameron, *supra* note 56, at 315.

⁹⁴ Physical dependence is not a necessary condition of addiction as defined by the World Health Organization's Expert Committee on Addiction-Producing Drugs. That organization defines drug addiction as:

a state of periodic or chronic intoxication produced by the repeated consumption of a drug (natural or synthetic). Its characteristics include: (1) an overpowering desire or need (compulsion) to continue taking the drug and to obtain it by any means; (2) a tendency to increase the dose; (3) a psychic (psychological) and generally a physical dependence on the effects of the drug; (4) an effect detrimental to the individual and to society.

See PRESIDENT'S REPORT 101.

This definition was necessary because the authors wanted to include cocaine and marijuana and other drugs that may produce psychological dependence but which do not produce physical dependence. However, this paper is concerned only with the opiates, all of which produce physical dependence. Furthermore, the President's Advisory Commission on Narcotic and Drug Abuse recently stated that only those drugs which produce physical and psychological dependence and tolerance are considered "truly addictive drugs." *Id.* at 2. There have been many definitions of "narcotic addiction," usually depending upon a particular author's context and purposes. See MAURER & VOGEL, *op. cit. supra* note 55, at 27-33. Several authors recently proffered a rather concise definition: "Drug addiction may be defined as a state in which a person has lost the power of self control with reference to a drug and abuses the drug to such an extent that the person or society is harmed." Vogel, Isbell & Chapman, *supra* note 55, at 1019.

⁹⁵ Isbell & White, *Clinical Characteristics of Addiction*, 14 AM. J. MED. 558 (1953).

case of heroin addiction, will probably begin to manifest itself within eight or ten hours of abstinence, reach a peak in twenty-four hours, and gradually abate within a week.⁹⁶ This illness is characterized, in the early stages, by yawning, rhinorrhea, lacrimation, perspiration and waves of gooseflesh; as time goes on, muscles twitch, the body aches, and hot and cold flashes are experienced. Extreme restlessness gives way to constant motion. Nausea, vomiting and diarrhea develop, and loss of weight, even as much as ten pounds in twenty-four hours, is experienced. The addict is in extreme misery.⁹⁷ "He may crawl into a corner, cover himself with a blanket even in the hottest weather, and beg piteously for a 'shot.'"⁹⁸ Death during "cold turkey" withdrawal, although rare, is not unknown.⁹⁹ It should be pointed out, however, that the severity of the withdrawal syndrome will vary depending upon the size of the habit the addict has acquired,¹⁰⁰ and many of today's addicts experience comparatively mild withdrawal because they have been injecting heavily adulterated or diluted doses of narcotics.¹⁰¹

As the addict develops tolerance and increases his dosage, he discovers that more and more of his time is consumed simply in obtaining and administering the drug. He must have four or five shots a day, and this entails repeated purchases and trips to the place where he has secreted his

⁹⁶ With morphine, the onset of the withdrawal syndrome comes in 12 hours, the peak is reached in 48 hours and remains for 24 hours; with demerol, onset is in 3 to 4 hours, peak from 8 to 12, and the effects disappear in 4 to 5 days. See *id.* at 560-62.

⁹⁷ The withdrawal syndrome or illness (also called the abstinence syndrome) is described well in MAURER & VOGEL, *op. cit. supra* note 55, at 84-87. For interesting studies of narcotics withdrawal see Himmelsbach, *Clinical Studies of Drug Addiction III*, 69 ARCHIVES OF INTERNAL MEDICINE 766, 771-72 (1942). See also Isbell & White, *supra* note 95, at 560; Kolb & Himmelsbach, *Clinical Studies of Drug Addiction*, 94 AM. J. PSYCHIATRY 759, 786-93 (1938).

⁹⁸ *Mental Health Monograph No. 2, supra* note 74, at 3.

⁹⁹ Cameron, *supra* note 56, at 315; Kolb, *Drug Addiction as a Public Health Problem*, 48 SCIENT. MONTHLY 391, 392, 398 (1939).

¹⁰⁰ More specifically, the syndrome will vary depending on the individual and the duration and the intensity of use. MAURER & VOGEL, *op. cit. supra* note 55, at 86; Cameron, *supra* note 56, at 315; Isbell & White, *supra* note 95, at 560.

¹⁰¹ The first White House Conference on Narcotic and Drug Abuse, held in Washington on Sept. 27 and 28, 1962, was addressed by President John F. Kennedy, who declared that "where 35 years ago addicts could purchase 100 per cent, or pure heroin, the sharply curtailed amount entering the United States today requires traffickers to dilute their product to the point that the addict obtains only 3 to 5 percent heroin in the packet that he purchases." BUREAU OF NARCOTICS, U.S. TREASURY DEP'T, *op. cit. supra* note 76, at 21; see Chapman, *supra* note 81, at 43.

paraphernalia for administration of the drug. He soon discovers that these excursions are incompatible with a full-time job, and so he becomes unemployed. He also discovers that his habit is beginning to cost him approximately twenty-five dollars a day,¹⁰² and this fact inevitably leads to more problems, which he will probably solve in one of two ways, or perhaps both: he may purchase a sufficient quantity to be able to sell the excess amount, after dilution, at a profit which will enable him to purchase a similar quantity and repeat the sales; or he may commit crimes such as housebreaking, larceny and shoplifting to obtain funds.¹⁰³ If he commits crimes against property, he will have to appropriate property worth many times the amount he needs because of its decreased value to a fence.¹⁰⁴ It appears that the majority of addicts support their habits by committing crimes against property. The Mayor's Advisory Council on Narcotic Addiction in New York City has concluded that the city's estimated 25,000 addicts spend between 500,000 and 700,000 dollars daily for narcotics, and that they raise this money by committing fifty per cent of the city's crime.¹⁰⁵

There are two prevalent theories concerning the relationship of narcotic addiction and crime. Law enforcement officials generally take the position that most addicts have engaged in criminal activities prior to their addiction, and that addiction is but one more manifestation of their basic antisocial pattern of living.¹⁰⁶ Those concerned with the treatment and rehabilitation of addicts generally conclude that criminal behavior on the part of addicts is usually directed toward obtaining funds to support addiction.¹⁰⁷ They base this conclusion on statistics demonstrating that

¹⁰² See *Mental Health Monograph No. 2*, *supra* note 74, at 7. A recent New Jersey survey estimates that the cost of drugs before the individual becomes addicted may run as low as \$5 a day, but after addiction it may soar to \$40 or \$60 a day. N.J. REPORT 66.

¹⁰³ Female addicts often turn to prostitution to support their habits. *Ibid.* It is interesting to note that addicts who can afford the high price of drugs usually do not engage in crime. See Howe, *An Alternative Solution to the Narcotics Problem*, 22 LAW & CONTEMP. PROB. 132, 133 (1957).

¹⁰⁴ A New York report estimates that an addict with a \$20-a-day habit might steal goods worth \$15,000 to support his addiction for one year. Meiselas, *supra* note 60, at 4.

¹⁰⁵ *Mental Health Monograph No. 2*, *supra* note 74, at 7.

¹⁰⁶ See, e.g., Anslinger, *Narcotic Addiction as Seen by the Law-Enforcement Officer*, Fed. Prob., June, 1957, pp. 34, 36.

¹⁰⁷ An excellent description of the relationship between narcotic addiction and crime is found in MAURER & VOGEL, *NARCOTICS AND NARCOTIC ADDICTION* 227-59 (2d ed. 1962). These authors explode the popular fiction that opiate addiction induces violent crime; to the contrary, they conclude that "the secondary effects of opiates are in the main so pleasant and so soothing that any violent psychopath will be deterred from following any impulses that he

addicts commit proportionately more nonviolent crimes against property and less violent crimes than nonaddicted individuals.¹⁰⁸ The addict is, of course, more likely to commit crime which will result in pecuniary gain; furthermore, because of his addiction, he is much less likely to commit violent crime, the effect of the opiate being a depressant one.¹⁰⁹ A report recently adopted by the American Medical Association states that "opiates are quieting drugs that repress hostile urges, create a passive, dreamy state and depress sexual drives."¹¹⁰ This report goes on to conclude:

There is no question that unstable antisocial persons have used opiates as long as these drugs have been known, and that such persons will continue to abuse these drugs seems a certainty. It is also true that a proportion of addicts did not engage in criminal pursuits prior to addiction and are not basically hostile, antisocial persons. What one cannot determine at present are the true relative percentages of these two types of persons. Both sides agree reasonably well that the majority of addicts do engage in crime (other than violation of the narcotic laws) after they become addicted in order to support their habits. There is also general agreement that the crimes committed by addicts are usually, but by no means always, crimes against property (theft, pickpocketing, shoplifting, confidence rackets) rather than crimes against the person (assault, murder, rape, and so on).¹¹¹

may have to commit violent crime" *Id.* at 233. They further conclude that the direct, physiological effects of opiates have little or no tendency to induce any type of crime, but that much nonviolent crime is committed by addicts attempting to support their habits. See generally LARNER & TEFFERTELLER, *THE ADDICT IN THE STREET* (1964); MEYERS, *SOCIAL AND PSYCHOLOGICAL FACTORS IN OPIATE ADDICTION* 82 (1952); Chapman, *Methods of Treatment and Management of Drug Addiction*, in *NARCOTIC DRUG ADDICTION PROBLEMS* 70, 73 (Pub. Health Serv. Pub. No. 1050, 1963); Chein & Rosenfeld, *supra* note 74, at 54; Firestone, *Narcotics and Criminality*, 22 *LAW & CONTEMP. PROB.* 69, 76 (1957); Kolb, *Factors That Have Influenced the Management and Treatment of Drug Addicts*, in *NARCOTIC DRUG ADDICTION PROBLEMS* 23, 27 (Pub. Health Serv. Pub. No. 1050, 1963). It is important to bear in mind that these observations are limited to the opiate drugs, which have a depressant effect on the user. A stimulant, such as cocaine, may very well have a tendency to induce violent crime. See MAURER & VOGEL, *op. cit. supra* at 236; Kolb, *supra* note 99, at 399.

¹⁰⁸ See *Mental Health Monograph No. 2*, *supra* note 74, at 7; Firestone, *supra* note 107, at 71.

¹⁰⁹ See KOLB, *op. cit. supra* note 85, at 16-18; AMA REPORT ON NARCOTIC ADDICTION 13; Wortis, *A Physician Views Today's Narcotics Problem*, in *NARCOTIC DRUG ADDICTION PROBLEMS* 174, 178 (Pub. Health Serv. Pub. No. 1050, 1963); note 107 *supra*.

¹¹⁰ AMA REPORT ON NARCOTIC ADDICTION 13.

¹¹¹ *Id.* at 15. Similarly, the *Report of Joint AMA-ABA Committee on Narcotic Drugs*, in *NARCOTICS ADDICTION* 41 (1963), states:

Some responsible authorities state that the physical and psychological dependence of addicts on narcotic drugs, the compulsion to obtain them, and the high prices of the

Perhaps the question of whether addiction preceded criminality or vice versa, although important, is not the crucial inquiry. Irrespective of his previous way of life, the addict must make the unhappy choice between kicking the habit, either by himself or with help, or financing it through crime. Perhaps the primary concern of the law should be the reasonableness of expecting him to choose the former.

SYNTHESIS

A threshold question is presented. When we hear it said that narcotic addiction is not a mental disease,¹¹² are we being confronted with a mere conclusory opinion which begs the essential questions of criminal responsibility outlined in the *McDonald* opinion, or is it being asserted that this condition does not constitute a "mental abnormality"? If the former, the validity of the conclusion will depend upon factors which vary from individual to individual, factors which must be presented to the trier of fact, with whom rests the ultimate responsibility for deciding this question. These factors will be considered subsequently. If the latter, however, the suggestion is that, since our conception of mental disease includes only *mental abnormalities* which produce the required impact on mental processes and behavior controls, narcotic addiction can never qualify, irrespective of its impact, because it is never a mental abnormality in the first instance. In other words, the *McDonald* definition of mental disease seems to require that a given condition be a recognized mental illness in the medical sense before a jury can be permitted to consider whether or not it constitutes a mental disease in the legal sense.

Although there may be differences of opinion among psychiatrists on the question whether narcotic addiction is a mental abnormality, it would seem that the weight of authority supports the affirmative view. The American Psychiatric Association's *Diagnostic and Statistical Manual* classifies narcotic addiction as a mental disorder.¹¹³ All authorities are agreed that the phenomenon of psychological dependence, which always accompanies

drugs in the illicit market, are predominantly responsible for the crimes committed by addicts. Others claim that the drug itself is responsible for criminal behavior. The weight of evidence is so heavily in the favor of the former point of view that the question can hardly be called a controversial one. . . . Crimes of violence are rarely, and sexual crimes are almost never, committed by addicts.

Id. at 44-45. See also N.J. REPORT 51-52.

¹¹² Such testimony is frequently heard from government experts at trials. See, e.g., *Heard v. United States*, —F.2d— (D.C. Cir. 1964); *Jackson v. United States*, —F.2d— (D.C. Cir. 1964).

¹¹³ DIAGNOSTIC AND STATISTICAL MANUAL 39.

addiction, represents some degree of modification of mental processes. The President's Advisory Commission on Narcotic and Drug Abuse recently stated:

All [narcotic drugs] profoundly affect the central nervous system and the mind. The effects produced by taking these drugs are primarily on the brain and range from euphoria through excitement to depression. . . . Many bring about a deep feeling that everything in life must be made to serve the purpose of maintaining a supply of the drug. These drugs are psychotoxic (mind poisoning). A psychotoxic drug is any chemical substance capable of adducing mental effects which lead to abnormal behavior. They affect or alter to a substantive extent, consciousness, the ability to think, critical judgment, motivation, psychomotor coordination, or sensory perception.¹¹⁴

It should be noted that the Commission was describing some of the immediate effects produced by administration of a narcotic drug, but it was also describing altered mental conditions which outlast the immediate feelings of euphoria, conditions which are the hallmarks of psychological dependence.

The courts should accept the proposition that narcotic addiction is a mental abnormality sufficient to raise a jury question of criminal responsibility. The *Heard* decision,¹¹⁵ holding to the contrary, should be reexamined. In deciding that the trial court had been correct in refusing to submit the issue of criminal responsibility to the jury, the court in *Heard* recounted the testimony of two psychiatrists who testified that the defendant was without mental disease or defect, and that he had no abnormal condition of the mind. One psychiatrist had testified as follows:

Q. And would you consider this condition [narcotic addiction] to be an abnormal condition of the mind?

[Objections intervened]

THE COURT: I will let her answer. Was it abnormal in the sense it is a mental disease or mental defect?

THE WITNESS: Abnormal in that it is not normal. Abnormal in the sense it is a mental disease in and of itself, no, it is not, Your Honor.¹¹⁶

¹¹⁴ PRESIDENT'S REPORT 1. Recent studies by Dr. Georges Ungar of the Baylor University College of Medicine indicate that tolerance to morphine (an opium derivative similar to heroin) produces chemical changes in the brain, which were observed when Dr. Ungar injected nonaddicted animals with brain tissue from addicted animals, and discovered that the injected animals immediately developed tolerance. Significantly, extracts of other tissues from addicted animals did not produce this phenomenon. Washington Post, April 14, 1965, p. A3, col. 5.

¹¹⁵ *Heard v. United States*, — F.2d — (D.C. Cir. 1964).

¹¹⁶ — F.2d at —, n.4.

It seems fair to conclude that this psychiatrist believed that narcotic addiction is a mental abnormality, but did not feel that it is a mental disease. In his dissent, Judge Wright pointed out that each of the expert witnesses testified that Heard's addiction would affect his mental and emotional processes and his behavior controls. He continued:

In short, each of them indicated that by our legal definition, as distinguished from their medical opinion, Heard may be suffering from a mental disease. Under the circumstances, it is difficult for me to understand why this is not the "some evidence" required to take the mental issue to the jury.¹¹⁷

The majority opinion in *Heard* placed considerable emphasis on an absence of testimony suggesting deprivation of narcotics at the time of the offenses, reasoning that no evidence of impairment of behavior controls was presented. This distinction is untenable for several reasons. To begin with, the addict is probably in need of four or five "fixes" per day. Is it reasonable to require him to wait until the onset of withdrawal to think about his next dose? The addict's entire life becomes dedicated to maintaining his supply; his need is constantly felt. He has experienced the panic of impending withdrawal many times, and he lives with this fear. Secondly, it would seem that in most instances evidence of deprivation could be obtained only through statements of the defendant, who will have every reason, under this ruling, to tell the psychiatrists that he needed a fix at the time in question. Thirdly, the majority ignored the impact of addiction on mental processes, which impact, it is submitted, is sufficient to raise a jury issue. This impact will not always be great, but it will always be present. Considering that the decision whether or not "some evidence" of mental disease has been offered requires that doubts be resolved in favor of granting the instruction,¹¹⁸ it is difficult to justify the *Heard* decision.

Assuming that a given addict-defendant has presented sufficient evidence of mental illness to warrant a jury instruction, the determination of criminal responsibility will depend on the nature of his addiction and its effect on his mental processes and behavior controls. To make an intelligent determination, the trier of fact must be given a sufficiently comprehensive picture of the defendant to permit a judgment regarding the impact of his addiction, together with whatever underlying disorder he manifests, on his mental and emotional processes and behavior controls. This is the obligation of the psychiatrist. His conclusion that addiction

¹¹⁷ — F.2d at —.

¹¹⁸ See p. 1025 *supra*.

is or is not a mental illness is of little or no value in this context.¹¹⁹ Each addict-defendant must be viewed as an individual whose mental processes and behavior controls have been to a certain extent affected and impaired because of his addiction. The legal question then becomes: is the extent of impairment with respect to the crime great enough to require exoneration? The trier of fact cannot be expected to answer this question on the basis of conclusory opinions.

It is submitted that the task of the expert witness should be to apprise the jury of the individual's personality structure and his addiction and the impact of these factors on mental processes and behavior controls with reference to the following variables: (1) the nature of the crime charged; (2) whatever underlying psychiatric disorder the individual manifests; (3) the amount of psychological dependence on the drug; and (4) the amount of physical dependence on the drug.

The nature of the crime the defendant is alleged to have committed is important mainly because it may rule out the possibility of causation by addiction.¹²⁰ If the crime is one of violence to the person, it would seem unrelated to the addiction, with the possible exception of robbery, which is usually committed for financial gain. If the crime is one against property or concerns the sale or possession of narcotics, it is the type of crime the addict commits to support his addiction, and the necessary causal connection is probably present.

As previously indicated, the underlying mental disorder itself may negate criminal responsibility.¹²¹ In most instances, however, the underlying disorder will be a personality disturbance which alone would present a close question under *Durham*. Here the dual function of the underlying disorder must be recognized. Not only does it bear directly on the *Durham-McDonald* formula, but also it relates to the degree of addiction proneness manifested by the individual. A thorough explanation of the factor of addiction proneness will enable the trier of fact to determine the extent to which the addiction of the defendant was nearly inevitable, given the first shot. If addiction proneness is slight, the jury may infer that the addiction merely fits into a pattern of antisocial activity. To this end, the jury should be given detailed information regarding the defendant's childhood, his environment, his relationship with his parents, his view of himself and his explanation of his addiction. Of particular importance

¹¹⁹ See text accompanying notes 27 & 28 *supra*; *Rollerson v. United States*, 343 F.2d 269 (D.C. Cir. 1964).

¹²⁰ See notes 107 & 109 *supra*.

¹²¹ See pp. 1029-30 *supra*.

is the defendant's description of his reaction to his first dose of narcotics. Did the drug miraculously provide the solution to all his problems, or was it merely a pleasurable experience worth repeating? Is the addiction the logical or even inevitable result of his personality structure, or could this individual have reasonably been expected to abstain from further use of the drug? It is believed that these judgments are usually made by the expert in arriving at his opinion; nevertheless, the jury should also be given the factual bases of the conclusion. It is interesting to note that when we speak of addiction proneness, we are considering the impact of the defendant's personality structure and mental processes on his addiction, that is, the extent to which this individual's psychological makeup dictated subsequent addiction given the initial dose. Closely related to this consideration is the impact of the addiction on mental processes, which is a function of psychological dependence.

Assuming that causation or productivity is not ruled out by the nature of the crime, the degree of the defendant's compulsion or need to continue using the drug would seem to be a critical factor. It is submitted that if this compulsion is sufficiently great, the addict-defendant should be exculpated, irrespective of underlying mental illness,¹²² although it would seem improbable that the compulsion could be great without at least some personality disorder. The degree of compulsion will be related to the psychological and physical dependence the individual has acquired. The extent of psychological dependence is usually a function of the underlying disorder, but it should be remembered that psychological dependence exists in addition to the mental disorder. In general, it

¹²² In the case of *Horton v. United States*, 115 U.S. App. D.C. 184, 317 F.2d 595 (1963), five noted psychiatrists, Lawrence Kolb, Herbert Modlin, Winfred Overholser, Leon Salzman and Joseph Satten, submitted an amicus curiae brief urging that the trial court erred in not granting judgment of acquittal by reason of insanity on the ground of narcotic addiction. They stated: "[T]he main issue should have been not what causes addiction, but how the affliction itself once established, affects its victims." Brief for Amici Curiae, p. 4. They designated the compulsion to continue drug use as a pharmacological duress, and asserted that no rational basis exists for differentiation between this form of duress and any other form of duress which relieves an individual of criminal responsibility. *Id.* at 5.

In *Castle v. United States*, —F.2d— (D.C. Cir. 1964), Judge Wright discussed the theory of pharmacological duress, based on the addict's apprehension of the withdrawal syndrome. He did not reach the point, however, nor did he comment on the validity of the theory.

Chen and Rosenfeld state that addiction, because of legal and financial implications, leads "to a syndrome of activities which establish [the addict] . . . firmly outside of the legitimate pursuits of his peers. Granted the fact of addiction, the victim has no real freedom of choice in the matter." Chen & Rosenfeld, *supra* note 74, at 54.

should be true that, the greater the degree of psychological dependence, the greater will be the compulsion to continue use of the drug. When we speak of psychological dependence, it should be remembered that we are not concerned with the addict's desire to avoid the withdrawal syndrome, but rather with his psychological need for the drug as a palliative. He may believe that he needs the drug to relieve physical illness, or he may feel the need to avoid extreme anxiety or unhappiness. In short, he may not feel able to bear his daily existence without the drug. It is in this sense that addiction affects mental and emotional processes and behavior controls. The expert witness should be able to describe the nature of the addict-defendant's psychological compulsion to continue using his drug. The trier of fact should consider whether use of the drug resulted from a genuinely felt need, or whether it merely reflected a desire to flout authority. One who has developed little psychological dependence, it is believed, should normally be expected to seek treatment rather than resort to criminality, for he ostensibly uses narcotics without substantial compulsion, although the necessity of avoiding the withdrawal sickness may represent a significant degree of compulsion if physical dependence is great.

If the addict has developed an immense habit, it may not be reasonable to expect him to seek treatment unless he displays no underlying personality disorder and little psychological dependence, in which case he should probably not be exculpated. Such an individual, however, is rare indeed. The compulsion which results from fear of excruciating withdrawal would seem to be substantial; however, with diluted narcotics, many addicts do not experience intense withdrawal symptoms, and in them the degree of physical dependence cannot be said to be great. In many instances it may be difficult to determine the amount of physical dependence because the addict will have undergone withdrawal before the psychiatrist sees him, and his own statements in this connection may not be reliable. The psychiatrist may, however, be able to find persons who observed the defendant during withdrawal, such as local jail personnel, and who may be able to furnish accurate information. Information regarding the length of time the individual has been using drugs and the daily dosage will also be useful in this connection.

The individual's compulsion, which would seem to relate directly to his ability to control his behavior with respect to a crime committed for financial gain, is thus seen as a function of psychological and physical dependence. If the expert is equipped with adequate knowledge of these factors in an individual case he should be able to assist effectively in the

determination of criminal responsibility under *Durham*. Although perhaps somewhat inconclusive, his testimony will be infinitely more valuable than would a mere conclusion that narcotic addiction is or is not a mental illness. The President's Advisory Commission on Narcotic and Drug Abuse, speaking of the individual who commits crime to finance his habit, recently stated: "Whether he can be held criminally responsible can only be decided in the courts, case by case. The Commission cannot assert a general rule that every confirmed drug abuser is so impelled by his habit that he is not accountable for his acts under criminal law."¹²³ The Commission is correct. The case-by-case determination need not be a guesswork process if the trier of fact is provided sufficient information. This is the obligation of defense counsel and the psychiatrist.

¹²³ PRESIDENT'S REPORT 3.